led services represent best practice. Standards: RCS guidelines state all emergency surgical patients should be reviewed by a consultant surgeon at least once every 24 hours.
Methods: All patients seen in ESAU GP unit had demographics, time of arrival, time of senior review. Data for 200 patients was retrospectively collected and analysed before introducing a consultant-led service in May 2014. Data for 360 patients was collected following this.
Results: 42.6% of patients were male, 57.4% female. Median age was 46. The service evaluation revealed that patients were waiting a median of 2 hours 20 minutes for a senior review. 39.5% of patients were being admitted to hospital via this clinic. Following intervention, median time for senior review was 1 hour 10 minutes. Rate of admission was 39.5% before and 38.3% after.
Conclusion: RCS standards were already being met. The service evaluation saw a reduction of 50% in waiting time for senior review. There was no significant reduction in patient admissions.

Posters: Upper-gastrointestinal Tract Surgery

0055: THE EFFECTS OF IMMUNONUTRITION IN UPPER GASTROINTESTINAL SURGERY: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Aim: The beneficial of immunonutrition on overall morbidity and mortality remains uncertain. We undertook a systematic review to evaluate the effects of immune-enhancing enteral nutrition (IEN) in upper gastrointestinal (GI) surgery.
Methods: Main electronic databases [MEDLINE via Pubmed, EMBASE, Scopus, Web of Knowledge, Cochrane Central Register of Controlled Trials (CENTRAL) and the Cochrane Library, and clinical trial registry (ClinicalTrial.gov)] were searched for studies reported clinical outcomes comparing standard enteral nutrition (SEN) and immunonutrition (IEN). The systematic review was conducted in accordance with the PRISMA guidelines and meta-analysis was analysed using fixed and random-effects models.
Results: Nineteen RCTs with a total of 2016 patients (1017 IEN and 999 SEN) were included in the final pooled analysis. IEN significantly reduced post-operative wound infection (risk ratio (RR) 0.69, 95% confidence interval (CI) 0.50 to 0.94). Although, the combined results showed that IEN had a shorter hospital stay (RR -2.51 days, 95% CI -3.47 to −1.55), there was significant heterogeneity observed across these studies. There was no statistically significant benefit on other post-operative morbidities of interest (e.g. anastomotic leak) and mortality.
Conclusion: IEN decreases wound infection rates and reduces length of stay. It can be recommended as routine nutritional support in upper GI surgery.

0109: LAPAROSCOPIC TRANSGASTRIC SUBMUCOSAL DISSECTION FOR EARLY GASTRIC NEOPLASIA

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Aim: Peroral endoscopic submucosal dissection is technically challenging, particularly at the gastro-oesophageal junction. We present two cases of laparoscopic transgastric submucosal dissection as an alternative for the management of early neoplasia at the cardia.
Methods: The first case (female aged 76) had previous endoscopic mucosal resection with persistent focal high grade dysplasia on biopsies, the second (male aged 64) had an inconclusive endoscopic biopsy suspicious for malignancy.
Both cases were offered laparoscopic transgastric endoluminal surgery. Standard laparoscopic equipment was inserted transabdominally and into the stomach under vision. Three trocars were placed into the gastric body for the laparoscopic camera and two instruments, providing an excellent approach to the gastro-oesophageal junction. The lesions were marked circumferentially, raised by submucosal injection and resected by submucosal dissection. The three gastrostomies were closed by laparoscopic sutures.
Results: After an excellent recovery the first patient was discharged on post-operative day 1; histology showed low grade dysplasia. The second patient was discharged on post-operative day 2; histology revealed poorly differentiated adenocarcinoma (pT1b).
Conclusion: The excellent visualisation, improved instrument handling and versatility provided by this novel technique facilitates endoluminal resection of lesions at the gastro-oesophageal junction that are beyond the scope of peroral endoscopy.

0158: THE SURGICAL MANAGEMENT OF ACUTE UPPER GI BLEEDING: EXPERIENCES FROM A DISTRICT GENERAL HOSPITAL

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Aim: Acute upper GI bleeding (AUGIB) is the most common reason for emergency gastroenterological admission to hospital, with only 2% patients requiring surgical intervention. Our aim was to review those patients undergoing surgery after presenting with AUGIB.
Methods: Data was collected retrospectively for all patients between March 2008 and March 2013. Outcomes were compared to the UK Comparative Audit of AUGIB.
Results: 328 patients presented with AUGIB during the study period. 65.9% were male and 34.1% female. The mean age was 65 years, Glasgow-Blatchford score 8.4 and 30-day mortality 5.2%. In total, 11 patients (3.4%) underwent surgery. 1 patient proceeded straight to surgery. The remaining ten patients underwent surgery following repeat bleeding. 3 patients underwent 2 UGIE before proceeding to surgery and the remaining 7 proceeded to surgery after 1 UGIE. Mortality in those undergoing surgery was 9% (1/11), which was considerably lower than in the UK audit. 5 patients were felt to be too frail for surgical intervention and were palliated. These patients tended to be older (mean age 80.2 vs. 69.4 years) than those undergoing surgery and have more co-morbidities.
Conclusion: Surgery for AUGIB is infrequent. Our results suggest that the appropriate selection of cases is important.

0168: AWARENESS OF UPPER GASTROINTESTINAL BLEED GUIDELINES AMONGST FOUNDATION TRAINEES

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Aim: Acute upper GI bleeding (UGIB) is a common cause of admission and carries a high mortality rate. NICE recently published guidance for managing acute UGIB. We assessed the awareness of this guidance.
Methods: A short online survey comprising 10 questions was used. The survey was emailed to foundation doctors in our trust.
Results: Pre-endoscopy - 57% stated they would use the Blatchford scoring system, whilst 43% chose the Rockall. Post-endoscopy - 23% stated they would use the Blatchford, whilst 77% chose the Rockall. 54.3% of the respondents stated they would not continue low dose aspirin after haemostasis had been achieved. 71.4% stated they would start a PPI at presentation. Regarding variceal bleeding - only 45.7% replied they would start antibiotics at presentation. 68.6% stated they would stop terlipressin after 5 days. For patients who rebleed 94.3% of respondents understood a repeat endoscopy is an option.
Conclusion: This survey is evidence that a large proportion of junior doctors are not aware of the latest NICE guidelines related to the management of UGIB. This in turn may impact on patient care. This also highlights the difficulty and the importance of keeping abreast of latest guidance and evidence for junior doctors.

0472: IS ROUTINE GROUP AND SAVE INDICATED FOR DAY CASE LAPAROSCOPIC SURGERY?

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